IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
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June 23, 2010

FerrenWeeks, Administrator
Yellowstone Group Home #4 (Fox Hollow)
560 West Sunnyside
Idaho Falls, Idaho 83401

RE: Yellowstone Group Home #4 (Hollow), Provider #13G066

Dear Mr. Weeks:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Yellowstone Group Home #4 Hollow, on June 15, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 6, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

TAYLOR BARKLEY
Health Facility Surveyor
Fire Life Safety & Construction Program

TB/lj

Enclosure

Printed: 06/22/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G066	A. BUILDING 02 B. WING _____	06/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 (FOX HOLI	370 HOLLOW DRIVE IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V (000) construction. It is fully sprinklered with Quick Response sprinklers and type 13 D system. Also there is a complete fire alarm/smoke detection system. The building was completed April 10, 1998. Currently the facility is licensed for 6 ICF/MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on June 15, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies, adopted 11 March, 2003. In accordance with 42 CFR 483.470. The annual fire/life safety survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000	Please see the attached plan of correction Jerem J. Wuchs	
K0148	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1 This Standard is not met as evidenced by: Based on record review it was determined that the facility did not have a smoking policy for the facility. The facility had a census of five clients on	K0148		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jerem J. Wuchs Regional Administrator 7/8/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K0148	Continued From page 1 the day of the survey. The findings include: During record review of the facility's policies on June 15, 2010 at 10:27 AM, it was determined that the facility did not have a smoking policy in the facility. Findings were noted by the Surveyor and the Facility Maintenance Manager. This deficiency affected all staff and clients present on the day of the survey.	K0148		
K0154	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This Standard is not met as evidenced by: Based on record review it was determined that the facility did not have a fire watch policy for the facility in the event of a sprinkler system failure. The facility had a census of five clients on the day of the survey. The findings include: During record review of the facility's emergency plans on June 15, 2010 at 10:25 AM, it was determined that the facility did not have a fire watch policy in the facility. Findings were noted by	K0154		

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K0154	Continued From page 2 the Surveyor and the Facility Maintenance Manager. This deficiency affected all staff and clients present on the day of the survey.	K0154		
K0155	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This Standard is not met as evidenced by: Based on record review it was determined that the facility did not have a fire watch policy for the facility in the event of a fire alarm system failure. The facility had a census of five clients on the day of the survey. The findings include: During record review of the facility's emergency plans on June 15, 2010 at 10:25 AM, it was determined that the facility did not have a fire watch policy in the facility. Findings were noted by the Surveyor and the Facility Maintenance Manager. This deficiency affected all staff and clients present on the day of the survey.	K0155		

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 (FOX HOLLOW)	370 HOLLOW DRIVE IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Inital Comments The facility is a single story, type V (000) construction. It is fully sprinklered with Quick Response sprinklers and type 13 D system. Also there is a complete fire alarm/smoke detection system. The building was completed April 10, 1998. Currently the facility is licensed for 6 ICF/MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on June 15, 2010. The facility was surveyed under the LIFE SAFETY CODE, 1976 Edition, " Lodging and Rooming Houses " contained in Chapter 11, " Lodging and Rooming House Occupancies " and applicable provisions of Chapters 01 through 07, Chapter 17 and Appendices A and B of the Life Safety Code, Impractical Evacuation Capability in accordance with IDAPA 16.03.11. The annual fire/life safety survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K0154 Fire watch policy for sprinkler system failure.	MM309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jason J. Wilcox Regional Administrator 7/6/10

STATE FORM C21199 Y8KC21 If continuation sheet 1 of 2

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MM309	Continued From Page 1 2. K0155 Fire watch policy for fire alarm system failure. 3. K0148 Smoking policy	MM309		

Fire Life Safety Plan of Correction 7/6/2010
Home #4 Foxhollow #13G066

K0148
All staff will be in serviced on the policy and a copy will be placed in the home's Work Safety Manual. All staff will also be in serviced on the Work Safety Manual and its location in the home. The policy was located already in our Employee Orientation Packet and our Employee Handbook. To assure the policy is in our manuals it will be incorporated into our annual OSHA Annual Inspection Calandar.

Responsible person will be the Home Administrator to be completed by July 30th 2010

K0154
A fire watch policy has been developed and implemented in the event either system becomes inoperable as stated in life safety standards K0154 and KO155. Responsible party is Ferren Weeks, Regional Administrator and will be completed by 7/10/2010.

Currently when either system is in trouble or there is false alarm the maintenance person is to be notified immediately and if the maintenance person is unreachable then the Regional Administrator will be contacted. The maintenance person is to then:

1. Notify the Regional Administrator. (If maintenance person is unavailable the Regional Administrator will designate an employee to:)
2. Go to the location or direct the home staff how to correct the problem.
3. If unable to correct, our contract services will be contacted to correct the problem.
4. If unable to correct with in 4 hours then the fire watch policy will be implemented.

A copy of the Fire Watch Policies and Procedures will be provided to the Bureau. All staff will be in serviced on the policy and a copy will be placed in each homes Work Safety Manual. All staff will also be in serviced on the Work Safety Manual, its location in each home, and added to our Employee Orientation Packet.

Responsible person will be each Home Administrator to be completed by July 30th 2010.

K0155- Please refer to K0
154

MM309(1 & 2) Please refer to K0154

MM309 (#3) Please refer to K0148

Ferren J. Weeks Regional Admin 7/6/10